October 2, 2015

VIA ELECTRONIC SUBMISSION

Attn: Secretary Silvia Mathews Burwell
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Comments on Michigan's Second Waiver Proposal to Amend the Healthy Michigan Plan Demonstration

Dear Secretary Burwell:

The National Health Law Program (NHeLP) advocates, educates, and litigates at the federal and state levels to protect and advance the health rights of low income and underserved individuals. We appreciate the opportunity to comment on Michigan's proposal to amend the Healthy Michigan Plan demonstration.

In a letter to you dated December 18, 2013, NHeLP voiced its support for Michigan's Medicaid expansion and that expansion has been very successful. In addition to enrolling nearly 600,000 Michiganders, the program has produced significant savings to the State budget.[1] One early impact study also found an 85 percent reduction in uncompensated care admissions at several Detroit-area hospitals in the quarter after Medicaid expansion began.[2] Michigan now seeks to amend that successful program.

[1] Mich. Dep't Health & Human Servs. (MDHS), *Healthy Michigan Plan Progress Report: July 20, 2015*, http://www.michigan.gov/documents/mdch/Website_Healthy_Michigan_Plan_Progress_Report_12-01-2014_475355_7.pdf, (last visited July 27, 2015). A recent Mannatt study found that the expansion produced over $200,000,000 in state savings over the first 6 months after implementation. Deborah Bachrach, Patricia Boozang, and Dori Glanz, MANATT HEALTH SOLUTIONS, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, 6 (Apr. 2015), https://www.manatt.com/uploadedFiles/Content/5_Insights/White_Papers/Manatt_StateExpandMedicaid_4_9_15.pdf.

[2] Modern Healthcare, *After Medicaid expansion, Tenet Sees 85 percent Drop in Uninsured Admissions in Michigan*, CRAIN'S DETROIT BUSINESS (Aug. 18, 2014 2:43PM), available at http://www.crainsdetroit.com/article/20140818/NEWS/140819836/after-medicaid-expansion-tenet-sees-85-percent-drop-in-uninsured.

We recognize the State's interest in adapting the Medicaid expansion to meet competing State priorities. However, Medicaid law already permits substantial flexibility for the State to customize its Medicaid program. Among other things, Michigan may adjust benefits, implement and target cost sharing, and develop alternative delivery systems. In addition to this existing flexibility, Michigan has already received *extra* flexibility in its approved § 1115 demonstration project to test and evaluate a health expense account with premiums for its expansion population. Despite all this flexibility, Michigan's Department of Human Services (MDHS) now proposes unprecedented and far-reaching amendments that HHS cannot legally approve within the § 1115 statute.

The proposed amendment contains multiple provisions that have never been granted in the history of the Medicaid program. These provisions—including time limits on Medicaid eligibility, partial Medicaid expansion, and unprecedented high premiums and cost sharing (that multiple studies have already found harm limited income people)—do not satisfy the requirements that § 1115 demonstrations test true innovations that are likely to promote the objectives of the Medicaid Act. Rather, these amendments would clearly worsen care for Michiganders, set precedents that could harm Medicaid enrollees across the country, and at the same time significantly increase total federal spending.

For all these reasons, described in greater detail below, NHeLP urges HHS not to approve several of the waiver requests in Michigan's proposal to alter its Medicaid expansion. HHS should instead work with the State to bring the proposal into a legally approvable form that preserves Michigan's Medicaid program and its Medicaid expansion.

Public Process for this demonstration proposal

Before addressing the content of Michigan's proposal, we would like to discuss serious legal problems with the public stakeholder process of this proposal. Michigan submitted its proposal to HHS as an "amendment" to its Healthy Michigan Plan. Regardless of the label, the State seeks to impose major substantive changes to the demonstration. Michigan should not be allowed to make such changes – effectively implementing a new demonstration – and cloak that application as an "amendment" that gets held to a lower standard in the review and public engagement process. In our previous comments on the Health Michigan Plan—which was also approved under the label of an "amendment"—we urged HHS not to interpret demonstration applications in ways that subvert the new public process rules. While we believe the best fix would be to amend the 1115 transparency regulations at 42 C.F.R. §§ 431.408-.416 to also apply to all significant amendments, we thought that HHS had partially addressed our concerns

when it updated its STC template language to now apply many of the new transparency requirements to demonstration amendments.[3]

We were surprised and concerned that HHS seems not to have followed the updated procedure in this case. The terms and conditions of Michigan's current demonstration clearly require amendments to adhere to the public notice requirements of 42 C.F.R. § 431.408, which demand a "comprehensive description of the demonstration application or extension to be submitted to HHS that contains a sufficient level of detail to ensure meaningful input from the public."[4] The demonstration STC's also stipulate that, among other requirements, any amendment proposal must include a "detailed description of the amendment, including what the State intends to demonstrate via this amendment as well as the impact on beneficiaries" and a "description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions."[5] Michigan's proposal wholly omits these and other key elements necessary to evaluate the proposed changes on their merits. The proposal includes no discussion of the demonstration purpose of this amendment, no proposed changes to the evaluation plan, and no mention of how it will satisfy the requirements of § 1916(f) necessary to waive the 5% aggregate cost sharing cap. It is so vague on other details, such as how the State plans to track cumulative Medicaid eligibility or how the State would pay for Marketplace subsidies, that meaningful input is not possible.

Michigan is proposing new policies that would limit access to care and impose unprecedented cost sharing. Most alarmingly, it would be shocking if first-ever time limits in the Medicaid program were imposed based on the brief and vague proposal Michigan posted for public comment. In short, this proposal exemplifies why significant amendments to Medicaid waivers should always be subjected to the same notice, transparency and comprehensiveness requirements as new demonstrations and extensions.

HHS should never have accepted this proposal as a complete application. Such short cuts undermine the public's trust in government and leave the impression that the demonstration review process is arbitrary and capricious, or subject to the whims of politics. In light of this, we believe that HHS must proceed with extreme caution in reviewing the *substantive* flexibilities requested in this application; approval of disputed

[3] CMS, *Health Michigan 1115 Demonstration: Special Terms and Conditions*, 5 (Approved Dec. 31, 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf.
[4] *Id.*
[5] *Id.*

waivers which harm consumers may create legal problems given the underlying *procedural* violation.

Time limits have never been allowed and are contrary to the purpose of the Medicaid program.

HHS should not grant any waiver to allow a time limit to establish conditions on Medicaid eligibility, be it through § 1902(a)(8)--Medicaid's "reasonable promptness" requirement—or through a waiver of comparability. As a matter of law, the Medicaid Act does not authorize time limits in Medicaid, and numerous provisions of the Act explicitly prohibit them. Nothing related to the Affordable Care Act or Medicaid expansion changed the law in that regard. Indeed, the ACA was enacted, in part, to make sure of just the opposite – that people do not lose their health insurance coverage.

These proposed time limits are far beyond HHS's demonstration authority. To our knowledge, HHS has never approved a Medicaid program to implement time limits on an eligibility category in the half-century of Medicaid's existence. Although states have ample flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law.[6] There is no way to construe a time limit as a feature that would "promote the objectives of the Medicaid Act" as is required for a § 1115 demonstration. Barring individuals from enrolling (or arbitrarily cutting them off or charging them more) does not help furnish medical assistance to enrollees. It does the opposite. It also fails to serve any legitimate *demonstration* purpose as the only results of this policy are harmful and predictable: in four years, many enrollees will drop Medicaid coverage and some others will pay exorbitant costs. Notably, the State in its proposal has not even attempted to describe an experimental purpose, let alone a viable one. Lacking any insight from Michigan, we are left to guess.

HHS should instead set stringent standards and require compelling evidence to even consider any proposed demonstration waiving a core Medicaid provision like § 1902(a)(8) or introducing a fundamental change like a time-limit. Notably, the reasonable promptness requirement of § 1902(a)(8) has not only been a mandatory feature of Medicaid since the program was enacted, it is a bedrock requirement for other public benefit programs. The requirement was included in the Social Security Act of 1950, primarily in response to complaints that states had established waiting lists in administering their Aid For Dependent Children's (AFDC) programs, As the U.S. Supreme Court discussed in *Jefferson v. Hackney*, 406 U.S. 535, 545 (1972), the "reasonable promptness" requirement

[6] Social Security Act §§ 1902(a)(10)(A).

> was enacted at a time when persons whom the State had determined to be eligible for the payment of benefits were placed on waiting lists, because of the shortage of state funds. The statute was intended to prevent the States from denying benefits, even temporarily, to a person who has been found fully qualified for aid. See H.R.Rep. No. 1300, 81st Cong., 1st Sess., 48, 148 (1949); 95 Cong. Rec. 13934 (remarks of Rep. Forand).

Congress's objective is clear. Justice Rehnquist later used the requirement to furnish assistance "with reasonable promptness to all eligible individuals" as an example Congress knowing how to require states to take particular actions as a condition of receiving federal funding. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17-18 (1981) (citing *King v. Smith*, 392 U.S. 309, 333 (1968)).

Using demonstration authority to waive such an essential feature of the Medicaid provision to establish time limited conditions on eligibility would be wholly contrary to the program's intended objectives as stated in the statute and its legislative history. Approval of this request would set a precedent allowing states not to enroll individuals eligible for Medicaid based on any one of a myriad of potential justifications. We note that in the context of states trying to control Medicaid costs, such a policy would quickly become a cost-control mechanism proposed as a "demonstration," and as you know, numerous federal courts have found cost-driven policies cloaked as "demonstrations" to be illegal.

Time limits applied to health coverage are by nature arbitrary and capricious. For many individuals who face serious or chronic health challenges that impede their ability to work, even if they may not technically qualify as disabled or medically frail, Medicaid offers dependable and affordable coverage that supports their ability to generate income (full-time or part time) and may prevent them from otherwise becoming fully destitute.[7] Such individuals are also more likely to have lower incomes over an extended period of time (and thus be impacted by this proposed policy). Conditioning eligibility or raising coverage costs based on an arbitrary cumulative time limit would likely have a disproportionate impact on such individuals and, as a result, may violate the Americans with Disabilities Act and section 504 of the Rehabilitation Act—provisions that the Secretary is not authorized to waive as part of a § 1115 experiment. In addition, the State offers no policy-based evidence or support to justify imposing any time limit at all, let alone a specific time limit (48 cumulative months) and income range (100–138% FPL.) At this point, this waiver request has no evidentiary or experimental basis or potential.

[7] Moreover, the State has offered no evidence to merit confidence in the efficacy of its medically frail screening process.

Finally, we note that there is no corollary for time-limiting medical coverage in the Marketplace or in commercial health insurance, which both serve a higher income population with fewer health needs, and Michigan is proposing to charge individuals staying in Medicaid with premiums that are actually *higher* than the corresponding Marketplace premiums. This would contradict HHS' stated rationale for approving premiums in Medicaid above 100% FPL – comparability with Marketplace policy. Section 1902(a)(8) should not be waived, and HHS should set no precedent for time limits in Medicaid.

For individuals who remain in Medicaid after the time limit, Michigan's proposal requests unreasonable premiums and cost sharing in excess of legal limits and beyond what HHS has ever approved.

For individuals who reach the time limit and "choose" to stay in Medicaid, Michigan is requesting authority to impose Medicaid premiums at 3.5 percent of household income. The amendment also seeks to raise the State's Medicaid quarterly out-of-pocket cap to 7 percent. (The legal maximum is 5 percent.) These requests are not legally approvable for numerous reasons. First, because the cost sharing and premium provisions are not located in § 1902 of the Social Security Act, but in § 1916 and § 1916A, cost sharing and premium waivers fall outside the scope of the Secretary's demonstration authority. Section 1115 only permits waivers of provisions in § 1902.

Second, this proposed premium and cost-sharing structure does not meet the demonstration requirements of § 1115. Heightened premiums and cost-sharing do not promote the objectives of the Medicaid Act or help furnish care to enrollees. In fact they do the exact opposite, decreasing access to care and continuity of coverage.

Moreover, these proposals do not *demonstrate* anything. Numerous studies have already consistently established the negative impact of premiums and cost-sharing on low-income individuals. One model based on data from Medicaid and CHIP programs in four states found that a premium of three percent of household income would depress enrollment by nearly half.[8] Similarly, when Oregon imposed monthly premiums from $6 to $20 in its Medicaid program, nearly 45 percent of its enrollees dropped out within the first year.[9] Michigan's proposal provides neither justification nor experimental purpose for raising an individual's premium by 75% when she exceeds 48 months in the program. It appears to only serve the purpose of steering individuals to the Marketplace to reduce the State's budget, which courts have maintained is not a valid justification for an 1115 demonstration. As stated by one court, § 1115

[8] Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999).
[9] Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFFS. 1106 (2005).

> was not enacted to enable states to save money or to evade federal requirements but to 'test out new ideas and ways of dealing with the problems of public welfare recipients'. [citation omitted] … A simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement.

Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994).

To our knowledge, HHS has *never* approved an aggregate out-of-pocket limit above 5 percent in Medicaid, and it is difficult to imagine any circumstance under which exposing very limited income Medicaid enrollees to a substantially higher financial risk could be construed as promoting the objectives program. In any case, HHS has no authority to approve such a cost-sharing waiver unless it also meets all of the conditions of § 1916(f) of the Social Security Act, which Michigan's proposal fails to mention and which would create significant additional requirements for the State. Moreover, we ask you not to allow Michigan (or any other State) to engage in labelling or wordsmithing that treats what is actually cost sharing (thus tripping 1916(f)'s requirements) as something else.

Finally, we note that although HHS has approved premiums under limited circumstances in other state demonstrations, the Secretary has not approved premiums in excess of two percent of household income even though a number of states requested higher amounts. In setting premiums for Marketplace enrollees in this income range, Congress considered two percent of income to be the amount individuals could afford. Moreover, the Affordable Care Act as passed by Congress actually dictated that the vast majority of adults in this income range would not be subject to premiums at all, as the Medicaid expansion was mandatory. Only individuals who otherwise did not qualify for Medicaid, such as legal permanent residents who were under the five year Medicaid bar, would have had to pay the 2% premiums to purchase coverage.

For individuals who choose to enroll in the Marketplace after the time limit, Michigan's "choice" proposal is vague *and* appears to amount to a partial Medicaid Expansion, which HHS has repeatedly rejected.

Michigan's proposal gives long-term Medicaid enrollees the following choice: either stay in the Medicaid program and face nearly double the monthly premium and unprecedented cost-sharing or shift to Marketplace insurance with tax credits and cost sharing reductions. Michigan's proposal is vague on who will subsidize individuals who would select Marketplace coverage. The State's response to public comments suggests that it may be possible to waive § 1902(a)(8) as a mechanism to allow individuals to "opt out" of Medicaid eligibility, ostensibly so they might qualify for Federal Marketplace

subsidies.[10] *If* Michigan's intent is for the federal government to fully subsidize coverage for any former Medicaid enrollee who chooses to enroll in the Marketplace, such a policy would not be permissible under federal law, which prohibits individuals eligible for comprehensive Medicaid coverage from receiving Marketplace subsidies. Even if, against our recommendation, HHS granted a § 1902(a)(8) waiver related to time limits, such a waiver would not change the fact that the affected individuals are still Medicaid-eligible under the federal statute for the purpose of Marketplace subsidies, and thus would not be eligible for federal premium tax credits or cost sharing reductions. An individual with access to affordable Minimum Essential Coverage outside the Marketplace may not qualify for federal subsidies, and this provision cannot be waived under § 1115.[11] The fact that the State suggests it would allow such individuals to go back to Medicaid only underscores their continued Medicaid eligibility.

If, in contrast, Michigan intends to pay for the subsidization of the Marketplace coverage with state and federal Medicaid dollars, the possibilities for implementing a "choice" framework would increase. This would not cure the illegality of the time limits and the heightened Medicaid costs for individuals who choose to remain in Medicaid (discussed earlier), but it would mitigate some of the harm from the time limits for the individuals who choose the "Marketplace." We note that Michigan could retain the responsibility to pay its minimal state match for newly eligible Medicaid expansion adults and set up a premium assistance program similar to the one implemented by Arkansas.

We note that the policy consequences of Michigan's "choice" design are significant. If HHS approved Michigan to enroll Medicaid-eligible individuals in the Marketplace without paying state matching funds, it would amount to a partial Medicaid expansion, where a state expands Medicaid eligibility to a level below the 138% threshold established in Medicaid law (for example, up to 100% FPL), allows the remainder above that limit to enroll in the Marketplace (with subsidies when applicable), but collects the full ACA *enhanced* matching rate for the Medicaid portion of newly eligible enrollees. A number of states have previously requested waivers for partial expansion with enhanced federal match for newly eligible adults. HHS repeatedly refused to grant those requests. (It did approve Wisconsin's partial expansion without enhanced match, but Medicaid expansion without enhance matching funds would be a poor fiscal decision for Michigan.)

Moreover, HHS has made it clear that any proposal to implement partial expansion after 2016, under State Innovation Waivers, would have to maintain the "same level of coverage, affordability and comprehensive coverage at no additional cost to the federal

[10] Nick Lyon, Mich. Dep't Health & Human Servs., *Amendment to Michigan's Section 1115 Demonstration Known as the "Healthy Michigan Plan"*, Attachment D, 3 (Sept. 1, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa.pdf.
[11] 26 U.S.C. § 36B(c)(2)(B).

government" – something this proposed amendment does not do.[12] For the federal government, such a "partial expansion" is a huge cost-shift. The federal government would lose the state's Medicaid contribution *and* foot the entire bill for the more expensive Marketplace coverage for affected enrollees.[13] Thus, such a policy could not be approved under sections 1115 or 1332 due to budget neutrality and other technical reasons. And of course, if HHS approved Michigan's waiver as proposed, every state would seek similar permission to shift costs onto the federal government. We note it would also create other major coordination and administration problems. For example, if an individual were to opt into the Marketplace coverage and later get diagnosed with a debilitating or chronic condition, she would have no way of knowing that she might now qualify as "medically frail," and hence would once again be "Medicaid-eligible" without the higher Medicaid cost sharing.

In short:

- HHS cannot legally, and should not as a matter of policy, approve any time limits regarding Medicaid enrollment status.
- If, against our recommendation, HHS approves any such time limit scheme for Michigan, that framework must:
    - *Not* result in any individuals losing Medicaid eligibility after the time limit expires (*i.e*., individuals might have a choice of normal Medicaid expansion eligibility and Medicaid premium assistance as allowed under the various flexibility options of the Medicaid Act);
    - *Require* that, as Medicaid enrollees, all such individuals retain the benefits and protections due to Medicaid enrollees;
    - *Not* impose unprecedented premiums and illegal cost-sharing;
    - *Require* the State to cover the entire Medicaid expansion population in Medicaid in order to receive enhanced Medicaid expansion matching rates.

Conclusion

HHS should work with Michigan to bring their amendment proposal into a legally approvable form. Regardless of what any state statute says, HHS should not approve waiver requests that cannot be approved under the law, in particular the provisions that have *never* been approved in any Medicaid program. We urge HHS to work with

[12] CMS, *Medicaid/CHIP Affordable Care Act Frequently Asked Questions: Exchanges, Market Reforms, and Medicaid*, 11 (Dec. 2012).
[13] The Congressional Budget Office (CBO) previously estimated that federal spending for Marketplace coverage would run roughly $9,000 per enrollee, versus federal spending of $6,000 for Medicaid expansion coverage. CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, 4 (July 2012), https://www.cbo.gov/sites/default/files/43472-07-24-2012-CoverageEstimates.pdf.

Michigan's Department of Health & Human Services to preserve this successful program. We believe that a reasonable and legal demonstration that supports access to care for beneficiaries will ultimately be sustained in Michigan, and any effort to sabotage expansion will be held accountable by the 600,000 Michiganders whose health depends on Medicaid expansion.

Thank you for considering our comments. If you have any questions or need any further information, please contact David Machledt (machledt@healthlaw.org; 202-384-1271), Policy Analyst, or Jane Perkins, Legal Director (perkins@healthlaw.org; 919-968-6038), at the National Health Law Program.

Sincerely,

Jane Perkins
Legal Director